

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004539  
STATE FILE NUMBER  
183

042

1000

Registration District No. Primary Registration District No. Registrar's No.

FILED FEB 24 1959

300  
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City 3008	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2	Length of stay in lb 39 years	d. STREET ADDRESS (If outside, give location) (unknown)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JOHN WHITNEY BOLEY			4. DATE OF DEATH Month Day Year Feb. 13, 1959		
--	--	--	---	--	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1890	9. AGE (In years last birthday) 68	FUNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
----------------	---------------------------	---	----------------------------------	---------------------------------------	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar maker	10b. KIND OF BUSINESS OR INDUSTRY Cigar factory	11. BIRTHPLACE (City and state or country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Fred Nash Boley	13b. MOTHER'S MAIDEN NAME Emina Laura Perry	14. NAME OF HUSBAND OR WIFE Josephine Gall
---------------------------------------	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Records, State Hospital #2, St. Joseph, Mo
---	---------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 4 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cardiac Asthma, decompensated heart DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4342		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	---	--	---

21. I attended the deceased from Feb. 13, 1959 to Feb. 13, 1959 and last saw her alive on Feb. 13, 1959 Death occurred at 4:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) Mohammad Tahir M.D.	22b. ADDRESS State Hospital #2, St. Joseph	22c. DATE SIGNED 2/14/59
---	---	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 17, 1959	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
---	----------------------------	---	---

24. FUNERAL DIRECTOR Incehoffer, St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Feb. 19, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
---	---	---

All diseases in Part I must be causally related.

Dr. Mohammad Tahir

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Clarence W. Harrington* .....

Licensed Embalmer No. *329-5* .....

P. O. Address *St. Joseph, Mo.* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.